ATTENDING PHYSICIAN'S STATEMENT

State Form 45547 (R3/12-03)

STATE OF INDIANA
State Personnel Department Benefits Division
Disability Program

This form Is confidential per IC 5-14-3-4(A) (9)

Mail completed form to: JWF Specialty Co., Inc. (Third Party Administrator)
PO Box 40968
Indianapolis, IN 46240-0968
Telephone: (317) 803-7200 or (317) 574-7876
Fax: 317-574-7865

This form is to be completed without expense to the State of Indiana.

THIS SECTION IS TO BE COMPLETED BY EMPLOYEE / PATIENT *(Please Print)*

Name of patient	Date of birth *(month, day, year)*
Name of agency	
Job title	☐ MALE ☐ FEMALE

THIS SECTION TO BE COMPLETED BY PHYSICIAN

I. HISTORY

a.) When did symptoms first appear or accident happen?

b.) Has the patient ever had the same or similar condition? *(If Yes, state when and describe.)*
☐ Yes ☐ No ☐ Unknown

c.) Name(s) and address(es) of other treating physician(s).

Is the condition due to injury or sickness arising from patient's employment?
☐ Yes ☐ No ☐ Unknown

II. DIAGNOSIS

a.) Diagnosis *(including any complications)*:

b.) CPT Code

c.) If pregnancy, estimated date of delivery:

d.) Subjective symptoms:

e.) Objective findings *(including current x-rays, EKGs, laboratory data and clinical findings)*:

III. TREATMENT

a.) Date of first visit *(month, day, year)*:	b.) Date of last visit *(month, day, year)*:

c.) Frequency of treatment:
Weekly_____; Monthly_____; Other *(specify)*_____

d.) Nature of treatment *(including surgery and medications prescribed, if any)*:

III. TREATMENT (Continued)

e.) Has the patient been hospital confined? (If yes give name and address of hospital)

☐ Yes ☐ No

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f.) Dates confined from/ through:

IV. PHYSICAL IMPAIRMENT (* as defined in federal dictionary of occupational titles)

☐ Class 1- No limitation of functional capacity; capable of heavy work. No restrictions * (0-10%)

☐ Class 2- Medium manual activity * (15- 30%)

☐ Class 3- Slight limitation of functional capacity; capable of light work * (35- 55%)

☐ Class 4- Moderate limitation of functional capacity; capable of clerical / administrative (sedentary) activity * 60- 70%)

☐ Class 5- Severe limitation of functional capacity; incapable of minimum (sedentary) activity * (75- 100%)

☐ Other limitations: _____

V. MENTAL / NERVOUS IMPAIRMENT (If applicable)

a.) Please define "stress" as it applies to this claimant:

b.) What stress and problems in interpersonal relations has claimant had on job?

☐ Class 1 – Patient is able to function under stress and engage in interpersonal relations (no Limitations)

☐ Class 2 – Patient is able to function in most stress situations and engage in most interpersonal relations (slight limitations)

☐ Class 3 – Patient is able to engage in only limited stress situations and engage in limited interpersonal relations (moderate limitations)

☐ Class 4 – Patient is unable to engage in stress situations or engage in interpersonal relations (marked limitations)

☐ Class 5 – Patient has significant loss of psychological, physiological, personal and social adjustment (severe limitations)

☐ Other limitations: _____

_____

VI. WORK STATUS

a.) Date patient became totally disabled from this condition:	b.) Anticipate return to work date?

VI. REMARKS

(Limitations, therapy, etc.)

I declare that I have examined this report and the statement contained herein is to the best of my knowledge and belief true, correct, and complete. I further understand that a fraudulent misstatement in completing this form would result in a loss of benefits for my patient.

Name (Attending Physician) please print	Degree	Telephone number
Address (number and street, city, state, zip code)		
Signature		Date (month, day, year)